MANDATORY OUTPATIENT TREATMENT

I. MANDATORY OUTPATIENT TREATMENT (MOT)

A. INTRODUCTION

The State of Tennessee first enacted mandatory outpatient treatment (MOT) legislation in 1982. In 1987 the American Psychiatric Association endorsed the use of MOT under certain conditions. Most states have commitment statutes permitting MOT in some form. MOT generally refers to a court directing a person with severe mental illness to comply with a specified, individualized outpatient treatment plan that has been designed to prevent relapse and deterioration to the point that the person would meet involuntary commitment criteria.

The purpose of mandatory outpatient treatment (MOT) is to provide a less restrictive alternative to inpatient care for service recipients with a mental illness who require continued treatment to prevent deterioration in their mental condition and who will respond to a legal obligation to participate in outpatient treatment. MOT should always be carefully and rigorously implemented since it involves a loss of liberty for the service recipient. In Tennessee, persons who are non-compliant with MOT ordered under T.C.A. § 33-6-602 without good cause can be re-hospitalized and persons found non-compliant with MOT ordered under T.C.A. § 33-7-303(b) can be held in contempt of court because he or she has failed to comply with the obligations ordered by the court.

Mandatory outpatient treatment plans are designed for individuals who require continued treatment to maintain psychiatric stabilization and appropriate behavior, who are unlikely to do so voluntarily, but will respond to an authority imposing this upon them. Under MOT, a service recipient may be eligible for discharge from inpatient care subject to the obligation to participate in any medically appropriate outpatient treatment, including but not limited to psychotherapy, medication, or day treatment (T.C.A. § 33-6-602(2)). Ideally, the service recipient's recovery would be supported by the MOT plan so that the service recipient would be able to more actively participate in outpatient treatment without a legal obligation and the MOT could be discontinued.

The Tennessee laws governing the use of mandatory outpatient treatment can be found in Title 33, Chapter 6, Part 6 and Title 33, Chapter 7, Part 3, (specifically paragraph (b) of T.C.A. § 33-7-303), of the Tennessee Code Annotated.

B. Types of MOT in Tennessee:

There are 2 types of MOT in Tennessee, identified by the authorizing statute:

(1) **T.C.A. § 33-6-602**:
Applies to service recipients who are judicially committed to a hospital for involuntary care under Title 33, Chapter 6, Part 5, Tenn. Code Ann. who meet the criteria for MOT; this includes persons under "forensic" commitment pursuant to T.C.A. § 33-7-301(b) or T.C.A. § 33-7-303(c).

(2) **T.C.A. § 33-7-303(b)**:

Applies only to service recipients evaluated under T.C.A. § 33-7-303(a) (after adjudication as not guilty by reason of insanity) who do not meet commitment standards under Title 33, Chapter 6, Part 5, Tenn. Code Ann., and who meet the criteria for MOT.

As noted above, persons who are non-compliant with MOT ordered under T.C.A. § 33-6-602 without good cause can be re-hospitalized under the original commitment order. Persons found non-compliant with MOT ordered under T.C.A. § 33-7-303(b) can be held in contempt of court because he or she has failed to comply with the obligations ordered by the court; hospitalization of these individuals requires implementing involuntary commitment procedures under Title 33, Chapter 6, just like any other person in the community who may meet involuntary commitment criteria.

II. COORDINATING MOT

The mandatory outpatient treatment (MOT) process ordered under T.C.A. § 33-6-602 is a combined effort of the inpatient treating facility and the outpatient provider. Service recipients who are judicially committed to any hospital for involuntary care under Title 33, Chapter 6, Part 5, Tenn. Code Ann. may be candidates for MOT, whether they are in a facility operated by the Tennessee Department of Mental Health and Substance Abuse Services (TDMHSAS), a private facility or a facility operated by the federal Department of Veteran's Affairs. The TDMHSAS Regional Mental Health Institutes (RMHIs) have a staff member as MOT Coordinator to:

- Have overall responsibility for the management of mandatory outpatient treatment procedures including the development of a system for tracking, monitoring, and record keeping,
- Ensure that MOT statutory criteria are met and MOT procedures are implemented, and
- Provide discharge data to the TDMHSAS MOT Coordinator.

It is recommended that outpatient agencies providing services under MOT identify a staff member to serve as MOT Coordinator for such duties as:

- Have overall responsibility for the development of a system for tracking, monitoring, and record keeping,
- Monitor reviews of MOT status, assure copies of renewal, modification and/or termination documentation are sent to the appropriate persons, assure that court orders and MOT documents are present and up to date, and act as a liaison with the legal system when necessary, and
- Provide renewal, review, or termination data to the TDMHSAS.

Additionally, Part 6 of Title 33, Chapter 6 of the Tenn. Code Ann. identifies the "outpatient qualified mental health professional" (QMHP) as being responsible for completing renewal, review, and termination documentation and for filing affidavits of

noncompliance or determining noncompliance if the affidavit has been filed by another person. QMHP criteria are defined in T.C.A. § 33-1-101(20):

> "Qualified mental health professional" means a person who is licensed in the state, if required for the profession, and who is a psychiatrist; physician with expertise in psychiatry as determined by training, education, or experience; psychologist with health service provider designation; psychological examiner or senior psychological examiner; licensed master's social worker with two (2) years of mental health experience or licensed clinical social worker; marital and family therapist; nurse with a Master's degree in nursing who functions as a psychiatric nurse; professional counselor; or if the person is providing service to service recipients who are children, any of the above educational credentials plus mental health experience with children;

Any provider of outpatient services under MOT must have QMHP staff available to carry out the duties defined in statute. Specific actions to be taken with MOT cases are described in more detail, below.

T.C.A. § 33-6-602

III. CRITERIA FOR MOT FOLLOWING INPATIENT COMMITMENT - T.C.A. § 33-6-602

To be considered for mandatory outpatient treatment under T.C.A. § 33-6-602, a service recipient must be currently committed involuntarily under Title 33, Chapter 6, Part 5, Tennessee Code Annotated including individuals committed concurrently under T.C.A. § 33-7-301(b) (pre-trial defendants) or T.C.A. § 33-7-303(c) (persons found Not Guilty by Reason of Insanity; NGRI).

A. Inpatient Facility Responsibilities

When considering a service recipient for MOT, the treatment team from the releasing facility, together with the proposed outpatient provider, must assess whether the service recipient meets the statutory criteria for MOT found in T.C.A. § 33-6-602:

- The person has a mental illness or serious emotional disturbance or has a mental illness or serious emotional disturbance in remission, and
- The person's condition resulting from mental illness or serious emotional disturbance is likely to deteriorate rapidly to the point that the person will pose a likelihood of serious harm under T.C.A. § 33-6-501 (See Appendix B) unless treatment is continued, and
- The person is likely to participate in outpatient treatment with a legal obligation to do so, and
- The person is **not** likely to participate in outpatient treatment unless legally obligated to do so, and
- Mandatory outpatient treatment is a suitable, less drastic alternative to commitment.

B. Outpatient Provider Responsibilities

- Provide information to the inpatient facility staff on previous outpatient treatment, if known, to help determine whether the service recipient meets criteria for MOT;
- Assist the inpatient facility in determining if the service recipient meets the criteria for MOT.

If both the inpatient treatment team and the outpatient provider determine that the service recipient meets all of the statutory criteria, then the process moves to the development stage of the MOT plan.

Note:

In assessing a service recipient for MOT, if it is determined that the service recipient will **voluntarily** comply with outpatient treatment, then MOT is **NOT** appropriate for that service recipient.

If the service recipient will NOT comply with outpatient treatment even if legally obligated to do so, then MOT is **NOT** appropriate for that service recipient.

IV. DEVELOPING THE MOT PLAN

Developing the MOT plan must be a collaboration between the inpatient treatment team from the releasing facility and the qualified mental health professional in the community to allow the service recipient's treatment plan to benefit from the knowledge and experience of both.

Both the releasing facility and the outpatient provider must approve the MOT plan prior to the service recipient's discharge. The outpatient provider has no obligation to participate in providing services under MOT without involvement and agreement in developing the plan.

The MOT plan must be completed in a timely manner to prevent unnecessary delay of the service recipient's discharge. The MOT plan must be designed to maintain the service recipient's psychiatric stabilization and avoid deterioration of the service recipient's mental condition that would lead to the service recipient meeting the definition of "substantial likelihood of serious harm" (T.C.A. § 33-6-501). Despite being a legal obligation to participate in treatment, the MOT plan should be based on principles of recovery, supporting the service recipient's ongoing growth and development. The MOT plan must include necessary outpatient treatment including but not limited to:

- psychotherapy
- medication management
- day treatment/vocational/educational activity
- substance abuse monitoring and treatment
- housing
- case management and other support services

The Role of Risk Assessment in Planning for MOT

Risk assessment provides valuable information for developing an MOT plan which includes risk management strategies to reduce the risk of recidivism and avoid deterioration of the service recipient's mental condition that would lead to the service recipient meeting the definition of substantial likelihood of serious harm. This is particularly relevant for the development of MOT plans for service recipients found Not Guilty by Reason of Insanity (insanity acquittees), or those who were charged with an offense but had the charges dropped after being found incompetent to stand trial and committed to the hospital. Risk assessment involves the careful review of a service recipient's history for the identification of risk factors associated with a higher risk of recidivism. The Dynamic Risk Assessment Checklist completed for forensic service recipients in the hospitals can identify some risk factors. Research on recidivism of criminal offenders and insanity acquittees has identified a number of factors associated with increased risk for recidivism, including:

- substance abuse
- history of aggression
- previous failure on supervised release/MOT

- use of a weapon in the offense
- unemployment
- divorce or death of partner within past year
- criminal history (including history of juvenile detention)
- history of physical abuse (as victim)
- access to preferred victim or victim class (e.g. targeted person or class such as children/elderly)
- personality disorder

Please note that for a history of aggression, a risk assessment should determine the specific pattern of aggression, e.g. fighting with others while intoxicated or while psychotic, preemptory strike against imagined enemies when delusional, or spousal/partner abuse. For insanity acquittees, the evaluation of mental capacity at the time of the offense should be reviewed to determine exactly what feature of the person's mental illness was linked to the NGRI offense so that treatment can be developed to address the potential for re-offense.

Identifying risk factors for violent behavior helps to determine the relative likelihood of future aggression and facilitates the development of risk management strategies. Below are examples of the sort of risk management strategy that would be suggested by certain risk factors. Risk management strategies, like treatment interventions, should be tailored to the individual needs of the service recipient. Some treatment interventions double as risk management strategies. Some risk management strategies will apply to more than one risk factor.

Risk Factor	**Risk Management Strategy**
History of Substance Abuse	• Patient will not use alcohol or drugs not prescribed for treatment • Drug and alcohol screens will be conducted (define frequency) • Patient will participate in X drug and alcohol treatment
Prior aggression linked directly to psychiatric symptom (e.g. delusions)	• Patient's mental status will be evaluated (define frequency and who will conduct MSE) • Patient will take medication as prescribed • Staff will report non-compliance to MOT coordinator
Use of weapon in prior aggression	• Patient will not possess weapons
Pattern of aggression involves specific victim or victim class	• Patient will have no contact with (victim) • Patient will have no unsupervised access to children (if preferred victims are children)
Personality disorder/psychopathy	• Include mechanism for independent monitoring of treatment participation and compliance with MOT requirements
Unemployed/not engaged in meaningful activity	• Patient will participate in daily activity of living outside the home (e.g. day treatment/vocational training/education)

Failure on previous community release	• Include mechanism for independent monitoring of treatment participation and compliance with MOT requirements
Family/psychosocial issues	• Patient will participate in family therapy as indicated • OR patient will have no unsupervised contact with X family members
Arson	• Patient will not possess or have access to fire-starting materials (e.g. lighters, matches)
Suicide/Self-Injury	• Patient will participate in X mental health treatment • Patient will develop safety plan with identified staff to contact with recurrence of suicidal thoughts • Patient will participate in Dialectical Behavior Therapy provided by (agency/clinician)

A. Inpatient Facility Responsibilities

- Locate an outpatient provider who will provide treatment to a service recipient on MOT. Invite them to review the records and meet with the service recipient to begin treatment planning, if this is feasible.

Note: Not all out patient providers accept MOTs. Some providers will accept MOT cases but have a maximum number they can manage at any one time. You may want to involve the Managed Care Organization for the service recipient's behavioral health benefits in finding a provider, if necessary.

- Consult with the service recipient as required by law (T.C.A. § 33-6-603), and the adult service recipient's conservator, if any, to involve them in discharge and MOT planning.
- Consider the service recipient's declaration for mental health treatment, if applicable, in development of the plan.
- Include the service recipient's family when clinically appropriate and with the service recipient's authorization.
- Consult with the designated qualified mental health professional with the prospective community mental health agency.
- Negotiate a mutually acceptable MOT plan with the outpatient qualified mental health professional in a timely manner to prevent unnecessary delay of the service recipient's discharge.
- If the service recipient has no income and no financial resources, assist application for TennCare. If the service recipient is indigent and is not eligible for TennCare, contact TDMHSAS for information regarding available services including Targeted Transitional Services funding, the Behavioral Health Safety Net, or the Insurance Marketplace. (see "Payment," p. 17)

- **If the service recipient is under 18 years old**, the inpatient facility must consult with the child service recipient's parents, legal custodian, or legal guardian.

B. Outpatient Provider Responsibilities

- In developing the MOT plan with the releasing facility, consult with the service recipient, the service recipient's family if clinically appropriate and with the service recipient's authorization, the service recipient's conservator, if any, and, if the service recipient is a child, the service recipient's parents, legal custodian, or legal guardian.
- Consider the service recipient's declaration for mental health treatment, if applicable, in development of the MOT plan.
- **If the service recipient is a child (i.e. less than 18 years old)**, assist the inpatient facility with consulting with the child service recipient's parents, legal custodian, or legal guardian.

Note:

The services provided by the community mental health agency should reflect all of the service recipient's obligations to participate in treatment. If the agency has agreed to an MOT plan stating that the client will cooperate with weekly case manager visits, the agency should provide for that level of case management or make changes in the MOT plan.

V. FINALIZING THE MOT PLAN

A. Inpatient Facility Responsibilities

After the MOT plan has been developed:

- Ensure that the appropriate staff from the inpatient facility and the outpatient provider approve and sign the MOT plan.
- If the service recipient is currently committed to a RMHI under T.C.A. 33-7-303(c) having been found Not Guilty by Reason of Insanity, a second opinion is completed by a psychiatrist at the RMHI other than the attending psychiatrist.
- Proposals for furlough and/or discharge of service recipients who have been found Not Guilty by Reason of Insanity should be submitted to the Risk Management Review Committee via the Office of Forensic Services. Materials to be submitted include:
  - ✓ Commitment Order
  - ✓ Initial Psychosocial Assessment
  - ✓ VRAG, Initial RAC and most recent RAC
  - ✓ Most recent Staff Conference Note
  - ✓ Furlough/Discharge Plan
  - ✓ MOT Plan (if recommended) or aftercare plan

  The Risk Management Review Committee may make suggestions for modification of an MOT plan.

- Obtain the service recipient's consent to the MOT plan, to the extent practical. For children, obtain the consent of the parents, legal custodian, or legal guardian.

The service recipient does not have to agree to the plan, but the service recipient should understand the obligation.

- Inform the service recipient of his or her right to request court review of the MOT plan. The service recipient may request a judicial review of the MOT plan within forty-eight (48) hours after being advised of their eligibility for release under MOT (T.C.A. § 33-6-604).
- If the service recipient requests judicial review, the hospital has the responsibility to notify the court of the service recipient's request for judicial review of the MOT plan. The court shall hold a hearing within seven days of the notice from the hospital to determine whether the treatment plan is medically appropriate and legally permissible. [See Form MH-5211]
- Following the hearing, the court shall either approve the plan or request that the releasing facility and the qualified mental health professional modify the plan to correct deficiencies found by the court (T.C.A. § 33-6-604). [See Form MH-5212]
- Prior to discharge the hospital must provide a clear written statement of what the service recipient must do to stay in compliance with the plan to the following persons:
  - the service recipient;
  - the service recipient's parents, legal custodian, or legal guardian if the service recipient is a child;

- the service recipient's spouse or other adult family member with whom the service recipient would live;
- the service recipient's conservator, if any.

If the service recipient is a child, the releasing hospital shall provide a clear written statement of what the service recipient shall do to stay in compliance with the MOT plan to the service recipient, and the service recipient's parents, legal custodian, or legal guardian. The statement shall specify the duties of the child's parents, legal custodian, or legal guardian.

B. Outpatient Provider Responsibilities

- Ensure that the appropriate qualified mental health professional approves and signs the plan.
- Assist the inpatient facility in obtaining the service recipient's consent to the plan, to the extent practical.
- Assist the service recipient and family members in understanding the obligations required by the MOT plan. This should include a discussion of compliance issues like keeping appointments and taking medication as well as what actions will be taken should the service recipient be non-compliant. The service recipient should understand that if he fails to comply with treatment without good cause he is subject to be returned to the hospital.

VI. DISCHARGING THE SERVICE RECIPIENT ON THE MOT PLAN

A. Inpatient Facility Responsibilities

If the person does not request judicial review of the plan, or if the court approves the MOT plan after a hearing under T.C.A. § 33-6-604, then the person may be discharged unless discharge is subject to judicial review of release under T.C.A. § 33-6-708.

Judicial Review of Release (T.C.A. § 33-6-708)

A criminal or juvenile court which has committed a person involuntarily under Title 33, Chapter 6, Part 5 may determine at the time of commitment that, due to the nature of the person's criminal conduct which created a serious risk of physical harm to other persons, the person should not be discharged from the commitment without proceedings to review eligibility for discharge.

When the hospital's chief officer determines that the person is eligible for discharge, the chief officer shall notify the committing court of the desire to discharge and of the outpatient treatment plan approved by the releasing facility and the qualified mental health professional.

The court may order a hearing to be held within 21 days of receipt of the chief officer's notice. The court will send a notice to the service recipient, the chief officer, the service recipient's attorney, the service recipient's next of kin, and the district attorney general.

- If the court does not set a hearing and notify the chief officer within 15 days of receipt of the chief officer's notice, the chief officer shall release the service recipient.
- If the court sets a hearing to be held within 21 days of the chief officer's original notice, the service recipient shall attend the hearing, unless his or her presence is waived by counsel.
- The chief officer's opinion that the person is eligible for discharge is presumed to be correct, and the district attorney may challenge that opinion.
- If the court finds that the service recipient is not eligible for discharge by "clear, unequivocal and convincing evidence," the court shall order the service recipient's continued stay at the hospital under the original commitment.
- If the court finds that the service recipient is eligible for discharge, it shall order the service recipient's release from involuntary commitment in accordance with the recommendations of the chief officer.

When all requirements for discharge are met (including request for court review of the MOT plan by the service recipient or requirement for judicial review by the criminal or juvenile court if applicable), the inpatient facility must:

- Follow standard procedures of notifying the committing court of the discharge of a person involuntarily committed. The notice shall state that the discharge is subject to the obligation to participate in outpatient treatment (T.C.A. § 33-6-605). (Note: There is no requirement to send the committing court copies of the mandatory outpatient treatment plan. If this is desired, a release should be obtained from the service recipient.) [See Form MH-5210]
- Notify the outpatient qualified mental health professional or designated outpatient MOT Coordinator by telephone and document in the record that the service recipient is being discharged (this is the date that the MOT goes into effect). Be certain that the service recipient has an appointment with the QMHP and, if necessary, a supply of medication to last until they can be seen by the outpatient provider.
- Promptly send a copy of the signed MOT plan to the designated outpatient MOT Coordinator.
- File the MOT plan and notice to the court in the service recipient's medical record.
- Document in the service recipient's record the basis for the decision to discharge under mandatory outpatient treatment. Specifically address the legal criteria for MOT.
- Notify TDMHSAS MOT Coordinator of the discharge and provide the following information about the service recipient:
    - Name
    - Social security number
    - Outpatient provider accepting the MOT
    - Date of discharge
    - Renewal/Expiration date for MOT
    - Patient's legal status at the time of discharge
    - Patient's place of residence at the time of discharge
    - Committing court

B. Outpatient Provider Responsibilities

- Receive the MOT plan from the inpatient facility
- It is sometimes necessary for a representative from the outpatient provider to attend a court hearing if the court schedules a hearing under T.C.A. § 33-6-708. Consultation with the inpatient forensic coordinator is the best way to determine whether the outpatient provider should attend a hearing.
- Assure that the QMHP has a copy of the MOT plan
- Begin administrative and clinical duties to help the service recipient comply with the MOT plan

The date of discharge is the date the MOT becomes effective.

VII. MAINTAINING THE MOT PLAN UNDER T.C.A. § 33-6-602 IN THE COMMUNITY

A. Outpatient Provider Responsibilities

The MOT Coordinator of the outpatient agency and/or qualified mental health professional (QMHP) has the primary responsibility to maintain a reliable system for ensuring the completion of MOT renewals every six months if the service recipient continues to meet MOT criteria and of notification to the appropriate parties (see VII.A.3., below) of termination of the MOT when the service recipient no longer meets criteria for MOT. Under the statute, the QMHP is responsible for renewing or terminating the MOT.

MOT plans may be renewed, modified, terminated, suspended or allowed to expire. MOT under T.C.A. § 33-6-602 expires six months from the date of discharge or last date of renewal unless active steps are taken to renew the MOT obligation. The MOT obligation may be renewed an indefinite number of times, but should only be renewed as long as the service recipient continues to meet the statutory criteria for MOT described above. MOT plans may be modified or terminated at any point under the procedures described below. If a service recipient on MOT is psychiatrically hospitalized for any reason, the MOT obligation is suspended during the hospitalization. The MOT obligation does not expire during the period of suspension. Whether the patient continues to meet criteria for MOT should be revisited at the time of discharge.

> **Note**:
>
> In assessing a service recipient for MOT, if it is determined that the service recipient will **voluntarily** comply with outpatient treatment, then MOT is **NOT** appropriate for that service recipient.
>
> If the service recipient will NOT comply with outpatient treatment even if legally obligated to do so, then MOT is **NOT** appropriate for that service recipient.

1. Renewals (T.C.A. § 33-6-621)

During the sixth month after a service recipient is discharged on MOT (or after the last renewal), the qualified mental health professional must assess whether the service recipient continues to meet the following criteria:

- The service recipient has a mental illness or serious emotional disturbance or has a mental illness or serious emotional disturbance in remission, AND
- The service recipient's condition resulting from mental illness or serious emotional disturbance is likely to deteriorate rapidly to the point that the person will pose a likelihood of serious harm under T.C.A. § 33-6-501 unless treatment is continued, AND

- The service recipient is not likely to participate in outpatient treatment unless legally obligated to do so, AND
- Mandatory outpatient treatment is a suitable less drastic alternative to commitment

If the service recipient continues to meet these criteria, then the qualified mental health professional must file a notice of renewal with the committing court. [See Form MH-5222]

The QMHP must inform the service recipient of the decision to renew the MOT and of the service recipient's right to request a hearing in the committing court. If the person does file a request for a court hearing, the committing court must hold a hearing within 30 days to review the MOT plan and to determine whether the MOT plan should be renewed or whether the person should be discharged from the MOT obligation (T.C.A. § 33-6-622; See Form MH-5224).

Copies of the renewal must be sent to:
- the service recipient;
- the committing court
- the service recipient's conservator, if any;
- the service recipient's parents, legal custodian, or legal guardian if the service recipient is a child;
- the service recipient's attorney (if known);
- the discharging hospital; and
- the TDMHSAS MOT Coordinator.

If the service recipient does not request court review of the renewal, the MOT is automatically renewed with no action required by the court. Subsequent renewals must be filed every six months.

2. Expired/Lapsed MOTs (T.C.A. § 33-6-623)

The service recipient's obligation to participate in mandatory outpatient treatment terminates six months after the discharge or the last renewal of the obligation. If the QMHP fails to renew or terminate the MOT during the sixth month after discharge or the last renewal, the MOT automatically expires.

3. Termination (T.C.A. § 33-6-620)

At any time during the course of outpatient treatment, if the QMHP determines that the service recipient:
- is likely to participate in outpatient treatment without being legally obligated to do so, OR
- no longer needs treatment for mental illness or serious emotional disturbance,

then the QMHP shall **terminate** the MOT.

A notice of termination must be completed by the QMHP and filed with the committing court. [See Form MH-5221] Copies of the termination must be sent to:

- the discharging hospital;
- the committing court;
- the service recipient;
- the service recipient's parents, legal custodian, or legal guardian if the service recipient is a child;
- the service recipient's attorney; and
- the TDMHSAS MOT Coordinator

4. Transfers of MOTs between outpatient providers

If circumstances warrant the transfer of a service recipient to another outpatient provider, then:

- the transferring outpatient provider must coordinate the transfer of the MOT with the receiving qualified mental health professional.
- the MOT Coordinator at the transferring outpatient provider must contact the MOT Coordinator at the receiving outpatient provider to plan for the timely and orderly transfer.

Not all outpatient providers accept the care of service recipients on MOT. If the service recipient is a Tenncare member, contact the Managed Care Organization for assistance in finding a provider, if necessary.

The service recipient should sign a form for consent to release information. Then, all necessary records should be provided to the receiving outpatient provider including:

- a copy of the MOT plan;
- documentation of any modifications made to the MOT plan;
- a copy of the commitment order; and
- a copy of the last renewal.

If the transfer occurs during the month of renewal, the transferring outpatient provider should ensure that the renewal is completed prior to the transfer. If, in the process of arranging a transfer, a decision is made that the service recipient no longer meets MOT criteria, the termination should be filed by the transferring outpatient provider before the service recipient is transferred.

After all arrangements are completed, and the receiving outpatient provider has accepted and agreed on a date for transfer, the MOT Coordinator at the transferring outpatient provider should send a notice that the service recipient's MOT is being transferred to another outpatient provider to:

- the service recipient;
- the service recipient's conservator, if any;
- the service recipient's parents, legal custodian, or legal guardian if the service recipient is a child;
- the court;
- the service recipient's attorney;

- the discharging hospital; and
- TDMHSAS MOT Coordinator.

This notice must indicate the date that the transfer will be effective.

5. Modifying the MOT plan

At any time during the MOT obligation, the qualified mental health professional may negotiate changes in the MOT plan with the service recipient to better meet the needs of the service recipient, promote compliance and support recovery (T.C.A. § 33-6-606).

6. Payment

If the service recipient is not indigent or the person is not eligible for payment for services under any other governmentally or privately funded system, the person is responsible for payment for the services.

Payment issues are typically addressed prior to hospital discharge in determining what agency or agencies will provide services. If a service recipient who has no income and no financial resources is discharged under MOT, the service recipient should be assisted to apply for TennCare or, if not eligible for TennCare, the Mental Health Safety Net. Targeted Transitional Services funding may be needed temporarily when a service recipient is discharged if there is a delay in the availability of other benefits. Service recipients may also be able to access behavioral health benefits through the Insurance Marketplace.

VIII. NON-COMPLIANCE WITH THE T.C.A. § 33-6-602 MOT PLAN

Outpatient Provider Responsibilities

The agency staff (case manager, physician, and/or therapist) working with the service recipient should be familiar with the service recipient's MOT plan and should inform the MOT Coordinator and the qualified mental health professional who is the assigned treating professional if the service recipient is non-compliant (T.C.A. § 33-6-609). The treating professional should enlist the aid of the treatment team and make every attempt to restore the service recipient to compliance in the context of the therapeutic alliance with the service recipient.

The sub-sections below describe the various ways that non-compliance with MOT may be handled when the community mental health agency providing MOT services or others in the service recipient's life have reached a point where they believe that it is necessary to involve the court.

The process begins with the filing of an affidavit of non-compliance with the court and may take several different courses from there depending on the circumstances of the case.

Affidavits

When a service recipient is non-compliant with his or her MOT plan without good cause, an affidavit of non-compliance may be filed showing that the service recipient is out of compliance and is not likely to comply voluntarily.

An affidavit is simply a sworn statement, notarized and sent to the committing court or the court with the same jurisdiction as the committing court where the client resides, detailing non-compliance (T.C.A. § 33-6-609). For instance, if the committing court was the Hickman County Circuit Court but the service recipient was living in Davidson County, an affidavit could be filed in the Davidson County Circuit Court.

The affidavit must show that:

- The service recipient is required to be participating in mandatory outpatient treatment;
- The service recipient is, without good cause, out of compliance with the treatment plan; and
- The qualified mental health professional believes the noncompliance is not likely to be corrected voluntarily.

An example of an affidavit format in general use is included in the Forms section of this training manual and posted on the TDMHSAS website at http://tn.gov/mental/legalCounsel/ModelFormsMOT.html [See MH-5213].

Being out of compliance "without good cause" typically means the service recipient is voluntarily refusing to fulfill an obligation of the MOT. If a service recipient is unable to

fulfill the requirement due to circumstances beyond his or her control, such as transportation problems, development of a physical ailment, or cancellation of a service by a service provider, the service recipient would not be considered to be in violation of the MOT.

Affidavits of non-compliance can be filed by:

- A qualified mental health professional;
- Parent;
- Legal guardian;
- Conservator;
- Spouse;
- Responsible relative;
- Person who initiated the commitment proceeding of the service recipient; or
- Chief Officer of the discharging facility.

As noted above, the affidavit may be filed in the committing court OR any court with jurisdiction under Title 33, Chapter 6, Part 5 in the county where the person is living or being treated.

IX. COURT PROCEEDINGS

A. Court proceedings in the Community

After the affidavit is filed with the court, the court may issue an order for the service recipient to appear in court no later than five business days after issuance of the court order.

A copy of the affidavit and court order will be served to:

- the service recipient;
- the service recipient's attorney;
- the qualified mental health professional (QMHP); and
- the District Attorney if the discharge had judicial review of release under T.C.A § 33-6-708.

1. Service Recipient Appears In Court

If the service recipient responds to the notice and appears in court, the court shall hold a hearing to determine whether the service recipient is required to be participating in outpatient treatment and is not, without good cause, complying with the treatment plan (T.C.A. § 33-6-610(a)).

If the court determines that the service recipient:

- is complying with the treatment plan,

OR

- is out of compliance for good cause but will be restored to compliance without further action,

then the court shall release the service recipient (T.C.A. § 33-6-610(b)) and the MOT plan continues. [See Form MH–5215, which may be used for any of the court's findings, described below.]

If the court determines that the service recipient:

- is out of compliance with the plan without good cause and can be put immediately in compliance with the treatment plan and can be expected to stay in compliance without further hospitalization,

then the court shall make a written finding, order the service recipient to comply immediately, and dismiss the proceedings upon showing that the service recipient is in compliance (T.C.A. § 33-6-610(c); Form MH-5215 is also used for this finding).

If the court determines that the service recipient:

- is out of compliance with the plan without good cause,

AND

- cannot be put in compliance with the plan immediately,

OR

- cannot be expected to stay in compliance without further hospitalization,

then the court shall order the service recipient returned to the hospital from which he or she was discharged. The sheriff shall transport the service recipient as ordered and the hospital shall admit the person (T.C.A. § 33-6-610(d); MH-5215).

If a person is ordered to be re-hospitalized for noncompliance with the treatment plan after a hearing under T.C.A. § 33-6-610, the person shall be held under the authority of the original court order of commitment entered in the proceedings under Title 33, Chapter 6, Part 5. Please note that the MOT obligation is suspended upon hospitalization and does not expire during the period of hospitalization.

2. Service Recipient Does Not Appear In Court and Affidavit Filed By QMHP

If the QMHP has filed an affidavit of non-compliance, and the service recipient does not respond to the order to appear, the court shall order the service recipient taken into custody and the sheriff shall immediately transport the person to the hospital from which the person was discharged (T.C.A. § 33-6-611; Form MH-5216).

The hospital shall admit the person and give notice of the temporary recommitment and that a hearing under T.C.A. § 33-6-610 be scheduled. See court proceedings in the hospital section below. (Form MH-5217)

3. Service Recipient Does Not Appear In Court and Affidavit Filed By Someone Other Than The QMHP

If someone other than the QMHP has filed an affidavit of non-compliance and the service recipient does not respond to the order to appear, the court shall order that the service recipient be taken into custody and transported to the qualified mental health professional for examination. The officer who serves the order on the person shall take the person to the qualified mental health professional or the professional's appointed substitute (T.C.A. § 33-6-612; Form MH-5217).

If the QMHP determines that the service recipient:

- is complying with the treatment plan,

OR

- is out of compliance for good cause and will be restored to compliance without further action,

then the QMHP shall release the service recipient (T.C.A. § 33-6-614(a)) and notify the court of the basis for the release. [See Form MH-5219]

If the QMHP determines that the service recipient:

- is out of compliance with the plan without good cause and can be put immediately in compliance with the treatment plan and can be expected to stay in compliance without further hospitalization,

then the QMHP shall release the service recipient (T.C.A. § 33-6-614(b)) and notify the court of the basis for the release. [See Form MH-5219]

If the QMHP determines that the service recipient:

- is out of compliance with the plan without good cause,

AND

- cannot be put in compliance with the plan immediately,

OR

- cannot be expected to stay in compliance without further hospitalization,

then the QMHP shall contact the sheriff and the sheriff shall immediately transport the person to the hospital from which he or she was discharged. (T.C.A. § 33-6-615; See Form MH-5219). Please note that the MOT obligation is suspended upon hospitalization and does not expire during the period of hospitalization.

The hospital shall admit the person and give notice of the temporary recommitment and that a hearing under T.C.A. § 33-6-610 be scheduled. See court proceedings in the hospital section below. [See Form MH-5217]

B. Court proceedings in the Hospital

If the person did not respond to the order to appear following an affidavit filed by the QMHP, or if the QMHP has evaluated the person following the filing of the affidavit and determines that they are out of compliance without good cause, the sheriff will transport the person to the hospital from which the person was discharged.

The inpatient facility shall admit the person and make arrangements to hold a non-compliance hearing under T.C.A. § 33-6-610. Notice of the temporary recommitment, and that a hearing will be held under T.C.A. § 33-6-610, must be given to the:

- service recipient;
- service recipient's attorney;
- legal guardian;
- legal custodian;
- conservator, if any;
- spouse or nearest adult relative (including parent of a minor);
- outpatient provider qualified mental health professional;
- court which ordered the temporary recommitment of the person; and
- court where the hospital is located that has the same jurisdiction as the recommitting court.

The court shall schedule a hearing to be held under T.C.A. § 33-6-610 within five (5) business days.

UNDER NO CIRCUMSTANCES SHOULD THE INDIVIDUAL BE CONVERTED TO TITLE 33, CHAPTER 6, PART 2, TENN. CODE ANN. (VOLUNTARY) STATUS PRIOR TO THE NON-COMPLIANCE HEARING.

The court shall hold a hearing to determine whether the person is required to be participating in outpatient treatment and is, without good cause, not complying with the treatment plan.

If the court determines that the service recipient:

- is complying with the treatment plan,

OR

- is out of compliance for good cause and will be restored to compliance without further action,

then the court shall release the service recipient (T.C.A. § 33-6-610(b)). [See Form MH-5215]

If the court determines that the service recipient:

- is out of compliance with the treatment plan without good cause and can be put immediately in compliance with the treatment plan and can be expected to stay in compliance without further hospitalization,

then the court shall make written findings of fact and conclusions of law on the issues, order the person to comply immediately with the treatment plan, and dismiss the proceedings upon a showing the person is in compliance (T.C.A. § 33-6-610(c)).
[See Form MH-5215]

If the court determines that the service recipient:

- is out of compliance with the plan without good cause,

AND

- cannot be put in compliance with the plan immediately,

OR

- cannot be expected to stay in compliance without further hospitalization,

then the court shall make written findings of fact and conclusions of law on the issues and order the person re-committed to the hospital. [See Form MH-5215]

If a person is ordered to be re-hospitalized for noncompliance with the treatment plan, after a hearing under T.C.A. § 33-6-610, the person shall be held under the authority of the original court order of commitment entered in the proceedings under Title 33, Chapter 6, Part 5, and any other pending proceedings under Title 33, Chapter 6, Part 4 or Part 5, shall be dismissed. As noted above, the MOT obligation is suspended upon hospitalization and does not expire during the period of hospitalization.

X. READMISSION OF A SERVICE RECIPIENT ON MOT UNDER T.C.A. § 33-6-602

There are three ways in which a service recipient who is on MOT under T.C.A. § 33-6-602 may be readmitted to a hospital:

1. Admission that follows a non-compliance hearing; or
2. Admission following affidavit of non-compliance; or
3. Admission under some other process that is **NOT** due to non-compliance with MOT.

When a service recipient is readmitted, it is important that a process of evaluation begin immediately to determine if the service recipient continues to meet the criteria for MOT and if MOT remains a suitable less restrictive alternative to commitment.

A. Admission NOT due to non-compliance with MOT (T.C.A. § 33-6-608)

In the case of an admission that is **NOT** due to non-compliance with MOT, the obligation to participate in mandatory outpatient treatment is suspended while the service recipient is hospitalized.

1. Inpatient Facility Responsibilities

- The admission would proceed as usual per statutory provisions (e.g. Title 33, Chapter 6, Part 4).
- Notify the QMHP and/or MOT Coordinator at the outpatient provider as soon as possible of the admission and involve them in assessment and discharge planning.

The treatment team should immediately involve the outpatient provider in determining whether the service recipient continues to meet the criteria for MOT. When considering the history of compliance with MOT, be sure to ascertain if the QMHP has made changes in the MOT plan since the last discharge.

2. Discharge Considerations

If the service recipient is discharged prior to a judicial commitment under Title 33, Chapter 6, Part 5, the inpatient facility must notify the outpatient provider (QMHP) of the discharge and help coordinate the resumption of the MOT plan.

The inpatient facility must provide information about possible changes in the MOT plan (e.g. changes in medication). Recommendations can be given that might impact renewal or termination. Upon discharge, decisions regarding changes in the MOT plan, renewal, or termination of the MOT are the responsibility of the outpatient provider (QMHP).

If the service recipient is judicially committed under Title 33, Chapter 6, Part 5, the inpatient facility shall consider whether the person can be discharged:

- to voluntary outpatient treatment under T.C.A. § 33-6-706

OR

- whether the person is eligible for discharge only under T.C.A. § 33-6-602 (mandatory outpatient treatment).

When considering a service recipient for MOT, the treatment team from the releasing facility must assess whether the service recipient currently meets the statutory criteria for MOT. The criteria found in T.C.A. § 33-6-602 are listed below as a reminder:

- The person has a mental illness or serious emotional disturbance or has a mental illness or serious emotional disturbance in remission, and
  - The person's condition resulting from mental illness or serious emotional disturbance is likely to deteriorate rapidly to the point that the person will pose a likelihood of serious harm under T.C.A. § 33-6-501(See Appendix B) unless treatment is continued, and
- The person is likely to participate in outpatient treatment with a legal obligation to do so, and
- The person is **not** likely to participate in outpatient treatment unless legally obligated to do so, and
- Mandatory outpatient treatment is a suitable, less drastic alternative to commitment.

3. Outpatient Provider Responsibilities

- Provide information to the inpatient facility staff to help determine whether the service recipient meets criteria for MOT.
- Assist the inpatient facility in determining if the service recipient meets the criteria for MOT.
- Provide information on whether the service recipient benefited or did not benefit from MOT.

If both the inpatient treatment team and the outpatient provider determine that the service recipient meets all of the above criteria, then the process moves to the development stage of the MOT plan.

Note:

In assessing a service recipient for MOT, if it is determined that the service recipient will **voluntarily** comply with outpatient treatment, then MOT is **NOT** appropriate for that service recipient.

If the service recipient will NOT comply with outpatient treatment even if legally obligated to do so, then MOT is **NOT** appropriate for that service recipient.

If it is determined that the service recipient no longer meets the criteria for MOT, it is the responsibility of the QMHP at the outpatient provider to notify the court of the termination.

B. Readmission following non-compliance hearing (T.C.A. § 33-6-610)

When an affidavit of noncompliance has been filed in the community, the court in which the affidavit has been filed will hold a hearing to determine whether the person is required to be participating in outpatient treatment and is, without good cause, not complying with the treatment plan (T.C.A. § 33-6-610(a)). As noted above, affidavits may be filed in the committing court or the court with the same jurisdiction as the committing court where the client resides or is being treated.

If the court determines that the person is out of compliance with the treatment plan:

- Without good cause,
- That the person cannot be put in compliance with the treatment plan immediately,

OR

- The person cannot be expected to stay in compliance without further hospitalization,

then the court shall order the person re-committed to the hospital from which the person was released. The sheriff shall immediately transport the person to the hospital from which he or she was discharged (T.C.A. § 33-6-610(d); See Form MH-5215).

1. Inpatient Facility Responsibilities

The hospital shall admit the person and give notice of the recommitment to:

- the person's attorney;
- legal guardian;
- legal custodian;
- conservator;
- spouse or nearest adult relative (including parent of a minor);
- the qualified mental health professional;
- the committing court;
- if the discharge was under T.C.A. § 33-6-708, to the District Attorney General of the committing court (T.C.A. § 33-6-610(d)); and
- the TDMHSAS MOT coordinator

Upon readmission, the obligation to participate in mandatory outpatient treatment is suspended, and the obligation resumes upon discharge unless the obligation:

- has been terminated by the outpatient qualified mental health professional;
- has been terminated by the court;
- has expired; or
- the service recipient is discharged to voluntary outpatient treatment under T.C.A. § 33-6-706 (T.C.A. § 33-6-608).

After readmission, the treatment team must:

- assess whether the person can be discharged to voluntary outpatient treatment under T.C.A. § 33-6-706,

OR

- whether the person is eligible for discharge only under mandatory outpatient treatment (T.C.A. § 33-6-602). (See criteria listed above)

2. Discharge Considerations

If there is a decision to discharge on voluntary outpatient treatment and to discontinue the MOT, the inpatient facility should notify the following of the decision to discharge without MOT:

- the committing court;
- the outpatient MOT Coordinator and/or the qualified mental health professional;
- TDMHSAS MOT Coordinator;
- the service recipient; and
- the service recipient's attorney.

If the service recipient is a child, also notify:

- parents;
- legal guardian; and
- legal custodian.

If the decision is made to discharge under MOT, the above persons should be informed of the plan to resume the MOT obligation upon discharge.

3. Outpatient Provider Responsibilities

- Provide information to the inpatient facility staff to help determine whether the service recipient meets criteria for MOT;
- Assist the inpatient facility in determining if the service recipient meets the criteria for MOT; and
- Provide information on whether the service recipient benefited or did not benefit from MOT.

If both the inpatient treatment team and the outpatient provider determine that the service recipient meets the criteria for MOT, then the process moves to the development stage of the MOT plan.

Note:

In assessing a service recipient for MOT, if it is determined that the service recipient will **voluntarily** comply with outpatient treatment, then MOT is **NOT** appropriate for that service recipient.

If the service recipient will NOT comply with outpatient treatment even if legally obligated to do so, then MOT is **NOT** appropriate for that service recipient.

If it is determined that the service recipient no longer meets the criteria for MOT, it is the responsibility of the QMHP at the outpatient provider to notify the court and the hospital that discharged the patient of the termination.

C. Readmission following affidavit of non-compliance

If an affidavit of non-compliance was filed by the qualified mental health professional in the community, and the service recipient did not respond to the order to appear in court, the court will order the person taken into custody and immediately transported to the discharging hospital by the sheriff (T.C.A. § 33-6-611; see Form MH-5216).

If the affidavit was filed by someone other than the QMHP, and the service recipient does not respond to the order to appear, the court will order the service recipient taken into custody and transported to the QMHP (or the professional's appointed substitute) for evaluation (T.C.A. § 33-6-612; See Form MH-5218).

If the QMHP determines that the service recipient is out of compliance with the treatment plan without good cause, cannot be put immediately in compliance, and cannot be expected to stay in compliance without further hospitalization, then the QMHP must contact the sheriff and have the service recipient transported immediately to the hospital from which the service recipient was discharged (T.C.A. § 33-6-615; See Form MH-5219).

1. Inpatient Facility Responsibilities

The inpatient facility shall admit the person and give notice of the temporary recommitment to

- the person's attorney
- legal guardian,
- legal custodian,
- conservator
- spouse or nearest adult relative
- the QMHP,
- the court that ordered the temporary recommitment of the person, and
- the court where the hospital is located that has the same jurisdiction as the recommitting court,

and make arrangements to hold a non-compliance hearing under T.C.A. § 33-6-610.

If a person is ordered to be re-hospitalized for noncompliance with the treatment plan, after a hearing under T.C.A. § 33-6-610, the person shall be held under the authority of the original court order of commitment entered in the proceedings under Title 33, Chapter 6, Part 5, and any other pending proceedings under Chapter 6, Part 4 or 5, shall be dismissed. As noted above, the MOT obligation is suspended during the period of hospitalization and does not expire while suspended.

2. Discharge Considerations

a. If the Court Does Not Re-Commit the Service Recipient

If the court releases the service recipient after a hearing under T.C.A. § 33-6-610, the Inpatient Facility must notify:

- the QMHP (inform them of any treatment recommendations); and
- the TDMHSAS MOT Coordinator.

If the service recipient is a child, also notify:

- parents;
- legal guardian; and
- legal custodian.

b. If the Court Does Re-Commit the Service Recipient

When making decisions about discharge the Inpatient Facility must consider whether the discharge should be to voluntary outpatient treatment and discontinue the MOT, or if the service recipient should remain on MOT.

If the decision is that the person be discharged to voluntary outpatient treatment, and the MOT is discontinued, the inpatient facility should notify the following of the decision to discharge without MOT:

- the committing court;
- the outpatient MOT Coordinator and/or the qualified mental health professional;
- TDMHSAS MOT Coordinator;
- the service recipient; and
- the service recipient's attorney.

If the service recipient is a child, also notify:

- parents;
- legal guardian; and
- legal custodian.

If the decision is made to discharge under MOT, the above persons should be informed of the plan to resume the MOT obligation upon discharge.

T.C.A. § 33-7-303(b)

XI. CRITERIA FOR MOT UNDER T.C.A. § 33-7-303(b)

Court-ordered outpatient treatment under T.C.A. § 33-7-303(b) applies exclusively to individuals found Not Guilty by Reason of Insanity (NGRI) who do not meet involuntary commitment criteria after being adjudicated NGRI. When a person is found NGRI, the court must immediately order an evaluation of the insanity acquittee under T.C.A. § 33-7-303(a) to determine whether 1) the acquittee meets the commitment criteria of Title 33, Chapter 6, Part 5, or, if not, 2) whether the acquittee meets criteria for Mandatory Outpatient Treatment under T.C.A. § 33-7-303(b)(3), or 3) if the acquittee should be released with outpatient treatment but no MOT, or 4) if the acquittee may be released with no further need for treatment. Beginning July 1, 2009 the evaluations under T.C.A. § 33-7-303(a) are performed on an outpatient basis.

Service recipients appropriate for mandatory outpatient treatment under T.C.A. § 33-7-303(b) must meet the following criteria:

- Acquitted of a criminal charge by reason of insanity, AND
- Found to not meet commitment standards under Title 33, Chapter 6, Part 5.

AND

- Have a condition resulting from mental illness that is likely to deteriorate rapidly to the point that the person will pose a substantial likelihood of serious harm under T.C.A. § 33-6-501 (See Appendix B) unless treatment is continued.

XII. DEVELOPING THE MOT PLAN UNDER T.C.A. § 33-7-303(b)

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This MOT plan is a community-based treatment plan that should be designed to prevent the deterioration of the service recipient's mental condition to the point that the service recipient would pose a substantial likelihood of serious harm. The MOT plan should include necessary outpatient treatment such as:

- Psychotherapy
- Medication
- Housing
- Case management
- Day Treatment/Vocational/Educational activity
- Substance Abuse Services
- Support services

Generally, the outpatient evaluation provider's procedures for arranging, conducting, and submitting an evaluation of an insanity acquittee under T.C.A. § 33-7-303(a) mirror the procedures for completion of pre-trial evaluations under T.C.A. § 33-7-301(a). In most cases the provider will have previously evaluated the acquittee for competence to stand

trial and mental capacity at the time of the crime under T.C.A. § 33-7-301(a) and will have created a file for that evaluation. This file would contain previously collected material plus records from the RMHI if the defendant was evaluated on an inpatient basis, as is the case of most (but not all) insanity acquittees with support for the insanity defense. If an acquittee has not previously been seen by the provider, a new file should be opened. Information from any outpatient and inpatient providers should be collected on all acquittees.

The agency providing the evaluation under T.C.A. § 33-7-303(a) may not necessarily provide all or any of the services outlined in the MOT plan. The evaluator may contact and coordinate with any agency or agencies which may provide services in the MOT plan to determine what services are needed and which agency or agencies could best provide those services.

In developing the MOT plan, consider the service recipient's declaration for mental health treatment, if applicable. Specific consideration should be given to any treatment approaches that might have prevented the deterioration of mental condition associated with the NGRI offense. Please note that defendants found NGRI on an offense against persons (Title 39, Chapter 13) may be held in jail for up to 30 days from the evaluator's receipt of the court order to allow for the completion of the evaluation under T.C.A. § 33-7-303(a). This includes the development of a MOT plan. This evaluation must be completed quickly since there is no authority for detention beyond 30 days.

Please refer to the Role of Risk Assessment in Planning for MOT, pages 6-8, above.

XIII. FINALIZING THE MOT PLAN UNDER T.C.A. § 33-7-303(b)

After the MOT plan has been developed:

- Ensure that the appropriate qualified mental health professional (QMHP) with the outpatient provider approves and signs the MOT plan;
- Attach a copy of the plan to the evaluation conducted under T.C.A. § 33-7-303(a) being submitted to the court;
- Submit a copy of the court letter and MOT plan to the forensic specialist in the Office of Forensic Services.

The acquittee does not have to agree to the plan, but efforts should be made to help the acquittee understand the obligation.

If MOT under T.C.A. § 33-7-303(b) is recommended, the court will hold a hearing prior to ordering the MOT. The evaluator who submitted the letter to the court may be subpoenaed to testify at this hearing. If the court orders MOT, the provider should receive a copy of the order from the court. If a court order has not been received in 30 days the court should be contacted to request a copy of the order. The MOT becomes effective the date of the order and this date should be used for calculating when the six month report is due.

XIV. TERMINATION OF MOT UNDER T.C.A. § 33-7-303(b)

The obligation to participate in mandatory outpatient treatment continues until it is terminated by the court under T.C.A. § 33-7-303(b)(5). **The outpatient provider does not have the option to terminate the T.C.A. § 33-7-303(b) MOT**. The outpatient qualified mental health professional is responsible for filing a report with the district attorney general every six (6) months on the acquittee's continuing need for treatment. The QMHP can and should recommend termination when appropriate, but only the court can terminate the MOT obligation.
[See Form MH-5227]

XV. MAINTAINING THE MOT PLAN UNDER T.C.A. § 33-7-303(b) IN THE COMMUNITY

A. Outpatient Provider Responsibilities

It is the responsibility of the MOT Coordinator and/or qualified mental health professional to maintain a reliable system for ensuring the completion of MOT reviews every six (6) months.

1. Reviews

The six-month review of the MOT under T.C.A. § 33-7-303(b) must be filed with the district attorney general (T.C.A. § 33-7-303(b)(4)). This report is called a "review" rather than "renewal" as the MOT under T.C.A. § 33-7-303(b) does not expire automatically, unlike MOT ordered under T.C.A. § 33-6-602. The review must contain information about the status of the service recipient's compliance and continued need for treatment. Detailed clinical information is typically not necessary [See Form MH-5225]. The QMHP must carefully monitor compliance and strive to restore the service recipient to compliance if there are any problems. An attempt should be made to intervene early if it appears the service recipient's condition is deteriorating (e.g. medication changes, increased appointments, or contacting crisis services). **It is not necessary to wait for the six month review to report non-compliance or to take action to bring the service recipient into compliance.** [See Form MH-5226]

Copies of the six-month review must be sent to:
- The district attorney general of the committing jurisdiction;
- the service recipient;
- the service recipient's attorney; and
- TDMHSAS MOT Coordinator.

2. Expired/Lapsed MOTs

The MOT ordered under T.C.A. § 33-7-303(b) cannot expire or lapse automatically. Even if the QMHP fails to complete the review for the district attorney during the sixth month after discharge or the last review, the MOT is still in effect. **The MOT under T.C.A. § 33-7-303(b) can only be terminated by the court.**

3. Termination

As noted above, the MOT under T.C.A. § 33-7-303(b) can only be terminated by the court (see T.C.A. § 33-7-303(b)(5)). The QMHP cannot terminate MOT under T.C.A. § 33-7-303(b). If, during the course of outpatient treatment, the QMHP determines that the service recipient no longer needs treatment for mental illness or serious emotional disturbance, the QMHP should notify the court of his or her findings. However, the decision to continue or terminate the MOT under T.C.A. § 33-7-303(b) is made by the court. [See Form MH-5227]

4. Transfers of MOTs Between Outpatient Providers

If circumstances arise which warrant the possible transfer of a service recipient to another outpatient provider (e.g. desire to move to another community), the outpatient provider of MOT services responsible for filing six month reviews with the district attorney should contact other potential providers to discuss possible transfer. Note that not all outpatient providers (QMHP's) accept MOTs.

If another QMHP is found, the service recipient must sign an authorization for release of information for all necessary records to be transferred to the new QMHP including:

- a copy of the MOT plan;
- a copy of the court order for MOT under T.C.A. § 33-7-303(b); and
- a copy of all previous reviews.

After all arrangements are completed, and the receiving QMHP has accepted and agreed on a date for transfer, the MOT Coordinator (QMHP) at the transferring provider must send a notice that the service recipient's MOT is being transferred to another provider (QMHP) to:

- the service recipient;
- the district attorney general;
- the service recipient's attorney, and
- TDMHSAS MOT Coordinator.

If the transfer is scheduled during the month a review is due, the transferring QMHP must ensure that the review is completed prior to the transfer. This notice must indicate the date that the transfer will be in effect.

5. Changing the MOT plan

The outpatient treatment provider should notify the court immediately of any changes in the outpatient treatment plan if changes are made between six-month reports. A description of any changes in the outpatient treatment plan over the previous six months should also be included in each six-month report to the court. Changes do not require court approval.

6. Payment

T.C.A. § 33-7-303(f) allows the cost of treatment incurred as a result of the outpatient treatment required under T.C.A. § 33-7-303(b)(3) to be taxed as court costs. If funds are not available from other sources, the court should be billed for the cost of treatment. However, reimbursement from the courts has been very infrequent in the past.

If a service recipient who has no income and no financial resources has been ordered on MOT, the service recipient should be assisted to apply for TennCare or services of the Behavioral Health Safety Net. The service recipient may also be able to obtain health insurance with behavioral health benefits through the Insurance Marketplace.

XVI. NON-COMPLIANCE WITH MOT ORDERED UNDER T.C.A. § 33-7-303(b)

The agency staff working with the service recipient (case manager, physician, and/or therapist) should be familiar with the service recipient's MOT plan and should inform the MOT Coordinator and the qualified mental health professional who is the assigned "treating professional" when the service recipient is non-compliant. [See Form 17, MHDD-5226] The treating QMHP should enlist the aide of the treatment team and make every attempt to restore the service recipient to compliance.

If the service recipient cannot be restored to compliance with the MOT plan, the outpatient qualified mental health professional shall:

- Immediately notify the district attorney general by phone and promptly file a written report with the district attorney general of the non-compliance. The district attorney general may move the criminal court to cite the person for civil or criminal contempt for the non-compliance and may file a complaint in the criminal court under the provisions of Title 33, Chapter 6, Part 5;
- Provide a copy of the written notice to the service recipient;
- Provide a copy of the written notice to the service recipient’s attorney;
- Document the basis of non-compliance in the service recipient’s clinical record; and
- Provide court testimony if subpoenaed.

If noncompliance is documented in the six-month review, or a report of non-compliance is filed, the review or report should clearly indicate:

- Specific components of the MOT plan with which the service recipient is out of compliance;
- Actions the QMHP has taken to restore the service recipient to compliance with the MOT plan; and
- The recommended plan of action to the district attorney general (How do you want the court to respond to your report of non-compliance? What type of action or assistance is necessary to bring the service recipient into compliance?).

If the service recipient's condition appears to have deteriorated rapidly, the outpatient provider may wish to contact crisis services. Crisis services may be contacted whenever clinically indicated, regardless of the service recipient's compliance with MOT.

XVII. COURT PROCEEDINGS

If, following a complaint from the district attorney general, the court holds a non-compliance hearing, the court may:

- Terminate the MOT if the criteria are no longer met;
- Restore the service recipient to compliance and continue MOT;
- Find the service recipient in civil or criminal contempt of court and detain them accordingly;
- Request additional evaluation to determine if the service recipient currently meets commitment standards under Title 33, Chapter 6, Part 4 or 5.

XVIII. ADMISSION OF A SERVICE RECIPIENT ON MOT ORDERED UNDER T.C.A. § 33-7-303(b)

A service recipient cannot be readmitted directly to a hospital under the provisions of T.C.A. § 33-7-303(b). However, the court could ask that the person be reevaluated to determine if they currently meet commitment standards, and this could lead to commitment under Title 33, Chapter 6, Part 5. A service recipient might be admitted under procedures for emergency involuntary hospitalization whether or not the service recipient has been compliant with MOT.

A. Admission unrelated to T.C.A. § 33-7-303(b) MOT

The obligation to participate in mandatory outpatient treatment is suspended while the service recipient is hospitalized but will resume when discharged unless terminated by the court.

Regional Mental Health Institute Responsibilities

In the case of an emergency hospitalization under Title 33, Chapter 6, Part 4 or a commitment under Title 33, Chapter 6, Part 5:

- The admission would proceed as usual per statutory provisions.
- Notify the QMHP and/or MOT Coordinator at the outpatient provider as soon as possible to inform them of the admission and involve them in assessment and discharge planning.
- Notify the TDMHSAS MOT coordinator.

B. Discharge Considerations

1. If committed under Title 33, Chapter 6, Part 4

If the service recipient has been admitted as an emergency and is going to be discharged prior to a judicial commitment under Title 33, Chapter 6, Part 5, the inpatient facility staff must notify the QMHP of the discharge and help coordinate the continuance of MOT. The obligation to participate in mandatory outpatient treatment resumes upon discharge unless the obligation has been terminated by the court. The Regional Mental Health Institute must provide information or recommendations about possible changes in the MOT plan (e.g. changes in medication) to the service recipient and the QMHP. If the service recipient is being discharged from a private hospital, the outpatient MOT provider should consider making changes to the MOT plan to reflect any changes in aftercare treatment resulting from the period of inpatient treatment.

2. If committed under Title 33, Chapter 6, Part 5

If the service recipient is involuntarily committed under Title 33, Chapter 6, Part 5, the inpatient facility shall consider whether:

- to recommend that the MOT ordered under T.C.A. § 33-7-303(b) be terminated and the service recipient discharged to voluntary outpatient treatment;

OR

- the service recipient meets the criteria for MOT under T.C.A. § 33-6-602.

Following an involuntary commitment, it is possible that a service recipient already under T.C.A. § 33-7-303(b) MOT could also be placed on MOT under T.C.A. § 33-6-602. This would be done primarily to make it possible to re-hospitalize the service recipient under the non-compliance procedures under Title 33, Chapter 6, Part 6. In that case, the provisions of both types of MOT would need to be followed, including reporting to the district attorney general and the committing court at six-month intervals.

C. Outpatient Provider Responsibilities

- Provide information to the inpatient facility staff to assist in treatment and discharge planning;
- Facilitate a smooth flow back to the community at the time of discharge; and
- Notify the TDMHSAS MOT coordinator of the status of the MOT plan including any changes.